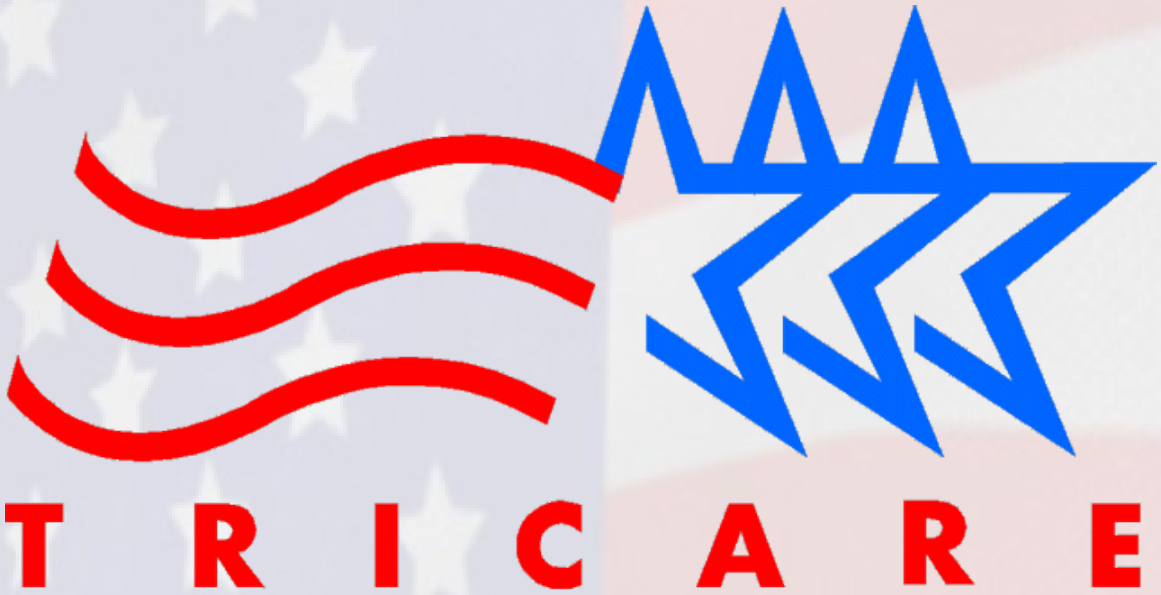


2000

“Focus on Performance”

Primary Care Management

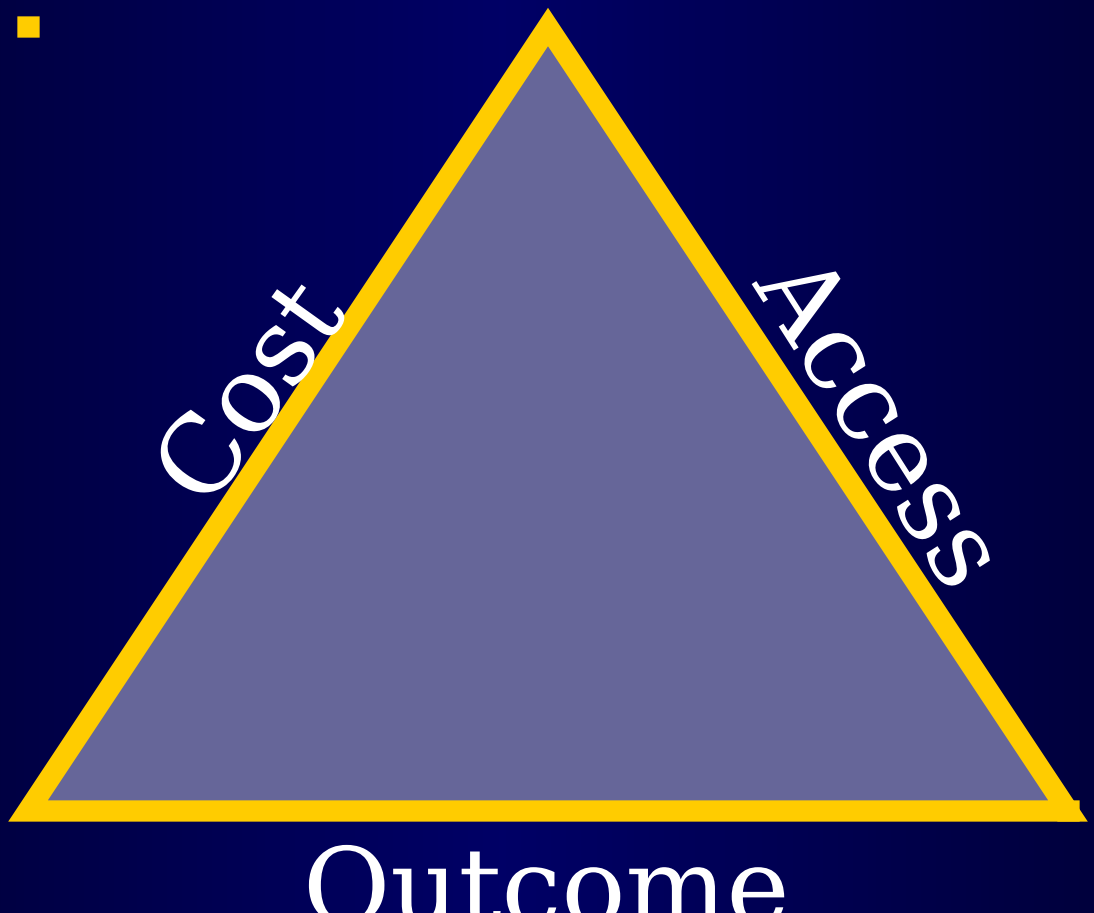
Five years of Lessons Learned Using an Enrollment Model

Robert Manaker, Lt Col USAF
Jon Pearse, Lt Col, USAF

Overview

- Cornerstones of Primary Care Management
- Setting Up/Implementing the Business Plan
- A Success Story- *One Approach*

The “Doctrine”



4 Cornerstones

- Staffing
- Physical Plant
- Demand Reduction
- Population Health

Staffing

USAF/SG:

"What the physician should do is focus on the customer for the Physical Exam part and the patient education piece…. *SOMEONE ELSE* should do everything else"

Staffing (*Cont*)

- Overall: 3-3.5 per PCM: .5 Nurse, 2 Medics, 1 Admin FTE
- Functionally Based, Team Based
  - Nursing (Triage, Phone advice, Patient care, Education, Prevention)
  - Medical Technicians (Patient Care, Prevention, Care-related Admin)
  - Admin (Records, Appointments, Secretarial, “Front Desk”

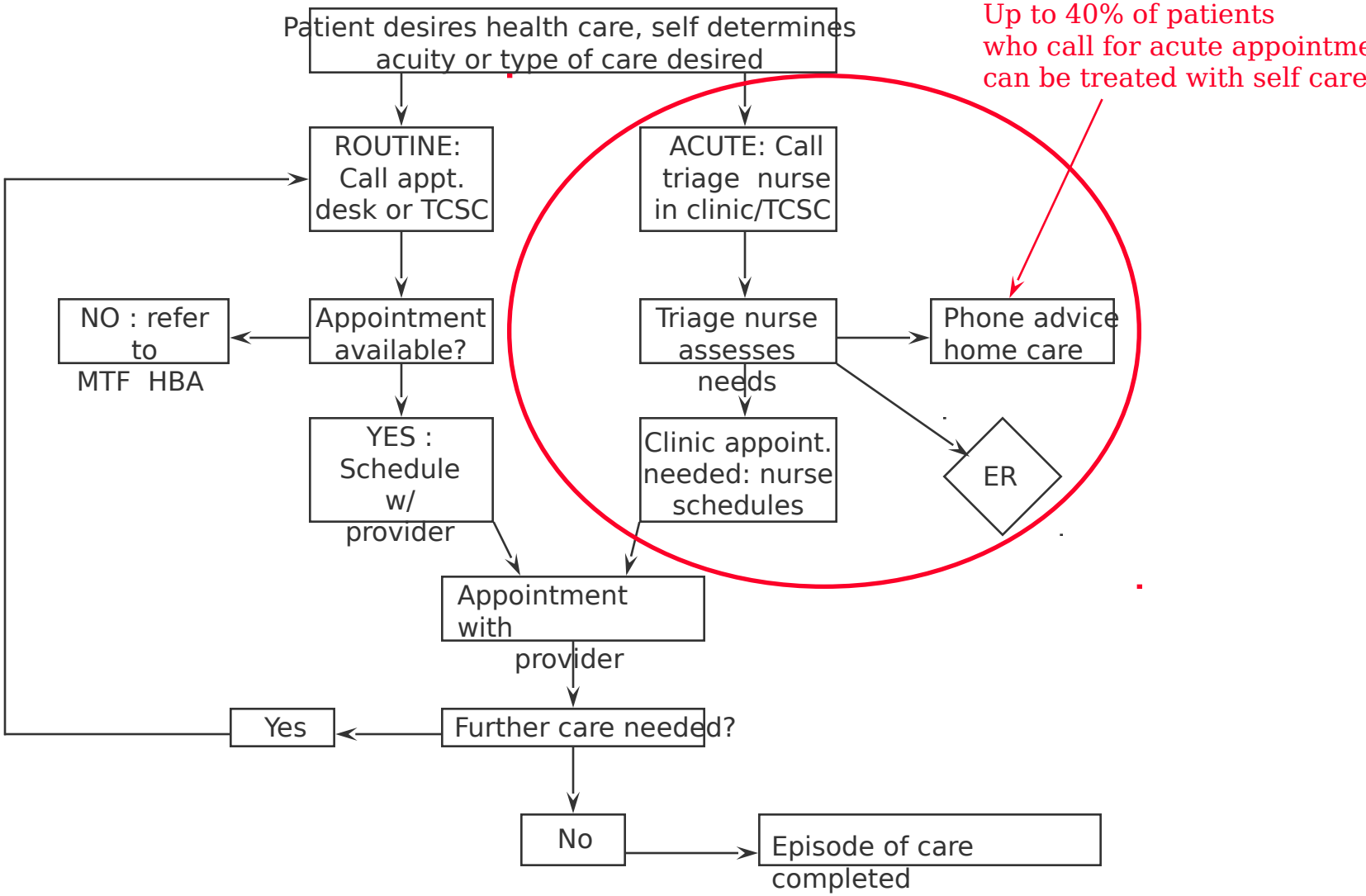
Physical Plant Essentials

- Patient Care
  - Two Exam Rooms/PCM
  - Private Office Space for PCM's, Clinical Nurses
- Administrative Support
  - Appointment/Triage section- *Physically in Clinic*
    - Adequate Phone Lines/Stackers
  - Records Room *Decentralize, Control Records*
    - Fax, Copier, Phones
- Other Common Areas- Waiting, Restrooms,etc

Demand Management

- Clinic Controlled Appointments
  - Few Templates
  - Triage Calls!
  - Effective Protocols
  - PCM-Nurse Team
    - Nurses Know Patients
    - Nurses Have Timely Access to Providers
    - Maximize Care Handled by Support Staff

Access Flow Chart


Patient desires health care, self determines acuity or type of care desired
Up to 40% of patients who call for acute appointme can be treated with self care
ROUTINE: Call appt. desk or TCSC
ACUTE: Call triage nurse in clinic/TCSC
NO : refer to MTF HBA
Appointment available?
Triage nurse assesses needs
Phone advice home care
YES : Schedule w/ provider
Clinic appoint. needed: nurse schedules
ER
Appointment with provider
Yes
Further care needed?
No
Episode of care completed

Population Health

"Prevent What You Can- Treat What You Must"

- *Not* Effective unless Empanelled
- Prevention
  - Identify Specific Risk Factors (HEAR, PHA (AF), Periodic Exam
  - Document and Track Services Needed Through Completion- (PHCA in AF)
    - Record, Paper or Electronic Should Have Snapshot
    - PCM Team is Driver, and Involved at All Levels
- Prevention = Future Demand Reduction

Cholesterol (Screen)

Total Records: 5974

DoD Standard

PCM Selected

NO PCM SELECTED

Males: 2900

Females: 1522

Not Met

Ben. Category	Population	Measure	Tot Records	Met Criteria	Percentage
Active Duty	Male and Female	Chol Screen last 5 years	2357	2136	90.62%
Family Member	Male and Female	Chol Screen last 5 years	309	265	85.76%
Retired	Male and Female	Chol Screen last 5 years	395	361	91.39%
Fam Mem of Retired	Male and Female	Chol Screen last 5 years	182	166	91.21%
Prime > 65	Male and Female	Chol Screen last 5 years	18	16	88.89%
Other	Male and Female	Chol Screen last 5 Years	34	33	97.06%
All	Male and Female	Chol Screen last 5 years	3295	2977	90.35%

SNAP-SHOT

< 60 %

60-79 %

> 79 %

People who report having their cholesterol checked within the last 5 years

Return to Main Menu

Return to Previous Menu

Start | Inbox - Microsoft O... | Find: Files named ha... | Harp | HARP Version 2.9... | Microsoft PowerPoi... | 7:32

Smoking

DoD Standard

Total Records	5974

Males	2900
Females	1522

Ben. Category	Population	Measure	Tot Records	Met Criteria	Percentage
Active Duty	Male and Female	Smokes Everyday/Some Days	2941	504	17.14%
Family Member	Male and Female	Smokes Everyday/Some Days	509	85	16.70%
Retired	Male and Female	Smokes Everyday/Some Days	431	90	20.88%
Fam Mem of Retired	Male and Female	Smokes Everyday/Some Days	229	51	22.27%
Prime > 65	Male and Female	Smokes Everyday/Some Days	25	2	8.00%
Other	Male and Female	Smokes Everyday/Some Days	39	6	15.38%
All	Male and Female	Smokes Everyday/Some Days	4174	738	17.68%

SNAP-SHOT

> 30 %

21-30 %

< 21 %

Met

People who report smoking every days or some days

Return to Main Menu

Return to Previous Menu

Population Health

- Disease Management
  - Outcome/Patient Based
  - Best Practice
  - Eliminates Variance/ Reduces Cost
- Data (HEAR) Based Selection of Targets
- Management Data = Outcome data
  - Clinical Focus Drives Business Practice

Where did all that money go?

Diagnosis Category	Dollars	Claims lines
Blood and blood forming Organs	$ 57,631.98	197
Circulatory System	$ 583,012.40	846
Conditions in the Perinatal Period	$ 157,021.04	146
Congenital Anomalies	$ 160,173.45	395
Digestive System	$ 261,518.56	1227
Endocrine, Metabolic, Nutritional, and Im	$ 123,489.08	618
Genitourinary System	$ 194,356.78	781
Infection and Parasitic Disease	$ 66,885.43	356
Injury and Poisoning	$ 258,583.59	1199
Mental Disorders	$ 386.10	6
MusculoSkeletal System and Connective	$ 415,140.68	1587
Neoplasms	$ 726,273.52	1851
Nervous System and Sense Organs	$ 271,461.95	2047
Pregnancy, Childbirth and Puerperium	$ 102,494.48	285
Respiratory System	$ 482,470.59	1905
Skin and Subcutaneous Tissue	$ 31,541.44	596
Symptoms, Signs, and Ill-Defined Condi	$ 811,899.50	9980
V Codes	$ 164,248.24	1481
Total	**$4,868,588.81**	**25503**

Five Years of Primary Care in An Empanelled Environment.....

The Primary Care Quality Improvement Project of 1994

- Organize--Team with a leader
- Customers identified as
  - **External**: Patients
  - **Internal**: ED, Commander, Women's Health Clinic, Surgery Clinic, Central Appointments, Dermatology, Pediatrics, Family Practice Clinic

The Process to Improve

- ***PATIENT ACCESS TO HEALTH CARE***
  - "An opportunity exists to improve the process of patient access to health care and provide continuity with primary care providers. Currently patients are seen by whatever provider has an open appointment. Some patient's frustrations include difficulty getting through on appointment lines, lack of appointments, need to access different clinics for care (Gyn, Peds, Derm, etc.) and seeing a different provider each visit." ***Empanelment improves access, provides continuity, provides care to entire families, and educates patients in preventive health care.***

The Process Improvement

- Empanelment: If we empanel 2000 patients per provider
  - Fewer patients present to EM with non-emergent problems
  - Decreased complaints on access to care
  - Decreased workload in central appointments
  - Patient see one primary care provider for continuity

Understand the Process

- ***Changing the "System"***
  - Telephone system/sequencer
  - Appointment availability
  - Appointment Clerks
  - Tracking/Identifying empaneled patients
  - Facility/Work space
- ***Staff Education***
- ***Patient Education***

Plan the Improvement and Continued Data Collection

- Define Population (40 mile catchment)
  - 80% AD 20% Retirees, Newborn to elderly, No OB
- Acquire/redesign space to improve professional appearance of clinic
- Improve appointment process
- Obtain appropriate equipment
- Improve skills of support staff common to family practice clinics
- Inform patients of options

Plan the Improvement *(Cont)*

- Obtain administrative support
- Develop patient education information
- Cost- Seek assistance from Managed Care to identify opportunities to show meaningful returns on investments

Advantages of Empanelment: Patient

- Greater Satisfaction
- Improved quality of care through continuity
- Less complicated appointment scheduling
- Less waiting time for appointments
- Educational opportunities for patient participation in prevention, health maintenance and curative measures
- Improved communication system reduces over-utilization of appointments

Advantages of Empanelment Provider

- Greater satisfaction and increased opportunity to perform:
  - diagnostic procedure
  - minor surgeries
  - flexible sigmoidoscopes
  - removal of cysts, skin tags, moles, toenails
- Covenant exists between doctor and patient
- Educational opportunities available to patients
- Improved quality of care through continuity
- Opportunity to see pediatric age patients

Advantages of Empanelment: Support Staff

- Greater efficiency working with specific provider
- Greater rapport with external customers through familiarity
- Greater opportunity to increase knowledge, skills, performance quality and accountability
- Greater satisfaction in job performance
- Collaborative practice with all staff

Do the Improvement, Data Collections and Analysis

- Additional space acquired Aug 94
- Additional staff May 94 - present
- Self help/new equipment Mar 94-present
- Redesign patient flow - “check in” to “check out” Oct 94
- Empanelment interviews start Oct 94
- Evaluate as needed and in Feb 95

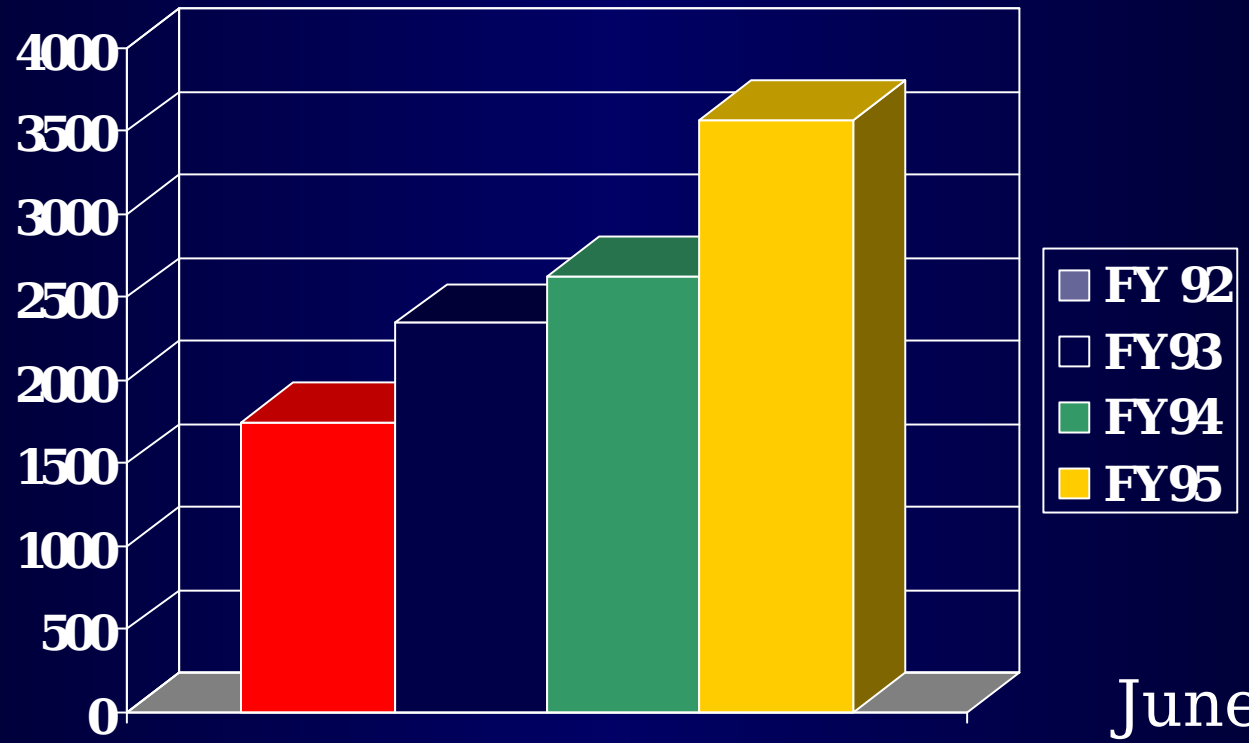
Check and Study the Results

- Did the process improve for patients? Questionnaires
  - Newly implemented, evaluate Feb 95
- Improvement to clinic personnel? Survey
  - like empowerment, tech/provider teams, pt flow and use of exam rooms, feel providing better care
- Continued Refinements?
  - Appointment type adjustments
  - Physician out on con leave x 4 months
  - Records/tech work space/application process/desk, leave, illness coverage/quarters processing
  - EM overflow/walk in's/PRX

Enrollment Goals and Pace

- Two providers per month--AD and families first then retirees
- Totals
  - 16,000 max into Primary Care Clinic (80/20 active/retiree)
  - 10,000 max into St Louis Army Clinic (80/20)
  - 7,000 max into Internal Medicine Clinic (all retiree)
  - 9,000 max into Family Practice Residency (70/30)
  - 4,000 est into Flight Medicine Clinic(all active)
  - **46,000 Patients**

Primary Care Clinic Outpatient Average Visits per Month



June 1995- 7800 were enrolled

Primary Care Clinic QA/QI Program: 10/94 Update

- Dept Chairperson has identified lack of continuity of care as #1 quality problem in PCCL. The step being taken to improve are:
  - 1. Decentralized appointments--Monday 24 Oct 94, appts were decentralized. 200-300 calls per day being answered with an average waiting time of 1 min 31 sec before call answered.
  - 2. Empanelment of patients -- 400 applications thus far from active duty and their families. Average 3 patients per family. 75 families seen and empanelled.
  - 3. Greater than 1 exam room/provider -- 1.5 exam rooms per provider on average currently.

Continued

- Department Key Processes
  - 1. Empanelment
  - 2. Access
  - 3. Documentation
  - 4. Education - staff and patients
  - 5. Provider Work Station (CIW)
  - 6. Appointments
  - 7. Nurse Utilization

Future Goals

- 1. Studies designed to view nurse and medical service specialist
- 2. Weekend clinic hours
- 3. Home Health Information Handbook

Primary Care Clinic QA/QI Program 9/95 Update

- 1. Decentralized appointments--90% of all daily appointments are made in the PCCL through 4 appt lines and f/u visits booked within the clinic. 10% booked by central appts for non-emp patients. Average 304 calls answered per day with hold time of 72 sec and 10 abandoned calls per day.
- 2. 9,000 patients empanelled

Update 9/95 ***(cont)***

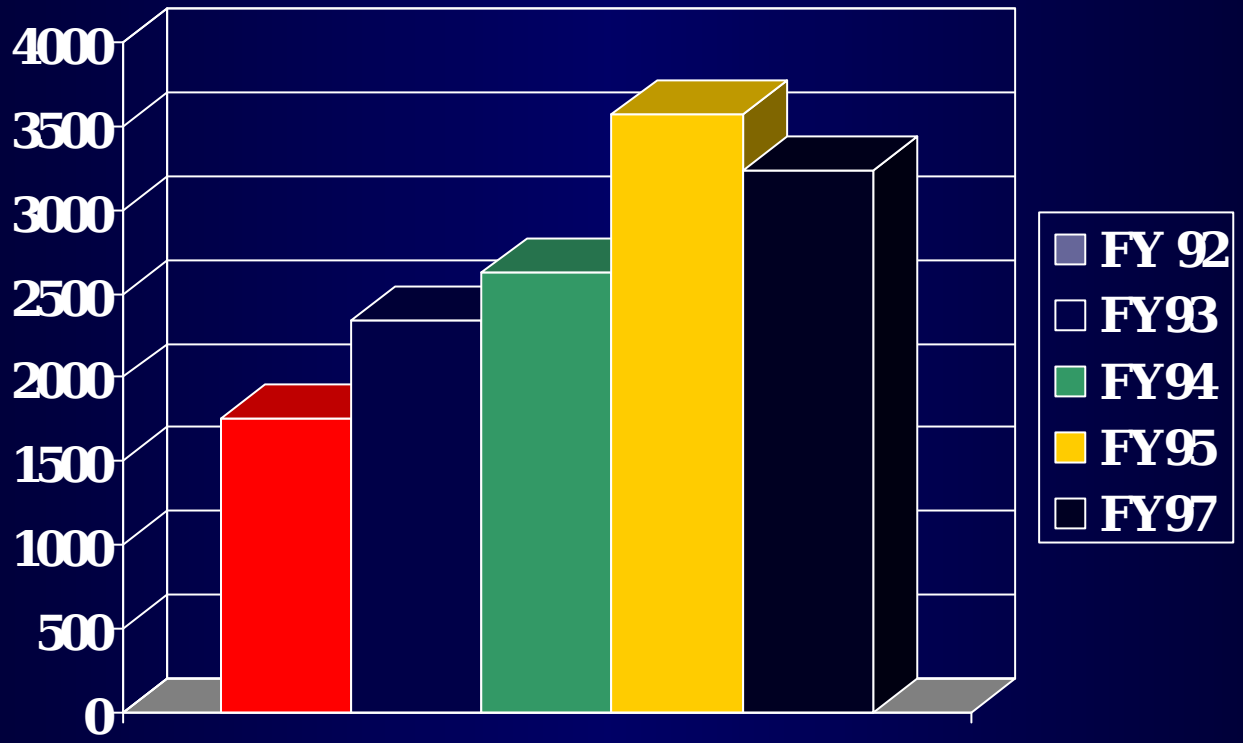
- 3. Greater than 1 exam rooms/provider-- 2 per provider
- 4. Mix 4 FP’s 4 PA’s, 2 FP’s expected, 4 RN’s.
- 5. Initial Telephone Triage 1 Sept 95

The Year in Review - 1997

The Year in Review -1997

- Two Locations-Scott and St Louis Market St
  - Scott Empanelment - 100%
    - 13,231 Total enrollment 1203/Provider
  - Market St Empanelment - 100%
    - 5,367 Total enrollment 1073/Provider
      - Assumed ownership Oct 1, 1997
- Appointment Line 200 calls per day
- Average Hold Time 70 sec
- No Shows Decreased from 331 (8%) to 199 (6%)

The Year in Review -1997



Enrollment=13,321

80% appointments filled

The Year in Review -1997

- Patient Prescription Refill Process Streamlined
- MHS Patient Satisfaction 87% #8-10 (n=23)
- MTF Patient Satisfaction 96% #5-6 (n=131)
- Staffing: Losses Gains
  - Providers-12 4 3
  - PA's-2 2 0
  - Nurses-6 3 3
  - Technicians-20 12 16
  - Admin-3
- Biggest Event-Began $330,000 renovation project
- Ended "Space A" tasking

The Year in Review -1997

- Enrollment Mix
  - Active Duty 4931
  - Active Duty Dep 6972
  - Retiree 480
  - Retiree Dep 570
  - Other ? 10

The Year in Review - 1998

The Year in Review - 1998

- Two locations-Scott and St Louis Market St
  - Scott Empanelment - 100%
    - May 1998 12,700 or 1190 per provider (Tricare)
    - December 1998 15,698 or 1427 per provider
  - Market St closed May-Dec 1998
    - Medicare patients transferred to Primary Care (352)
- Appointment Line 160 to 240 phone calls (Tricare)
- Average Hold Time 50 sec to 70 sec (Tricare)
- No Shows/Month 199 (6%) to 138 (4%)

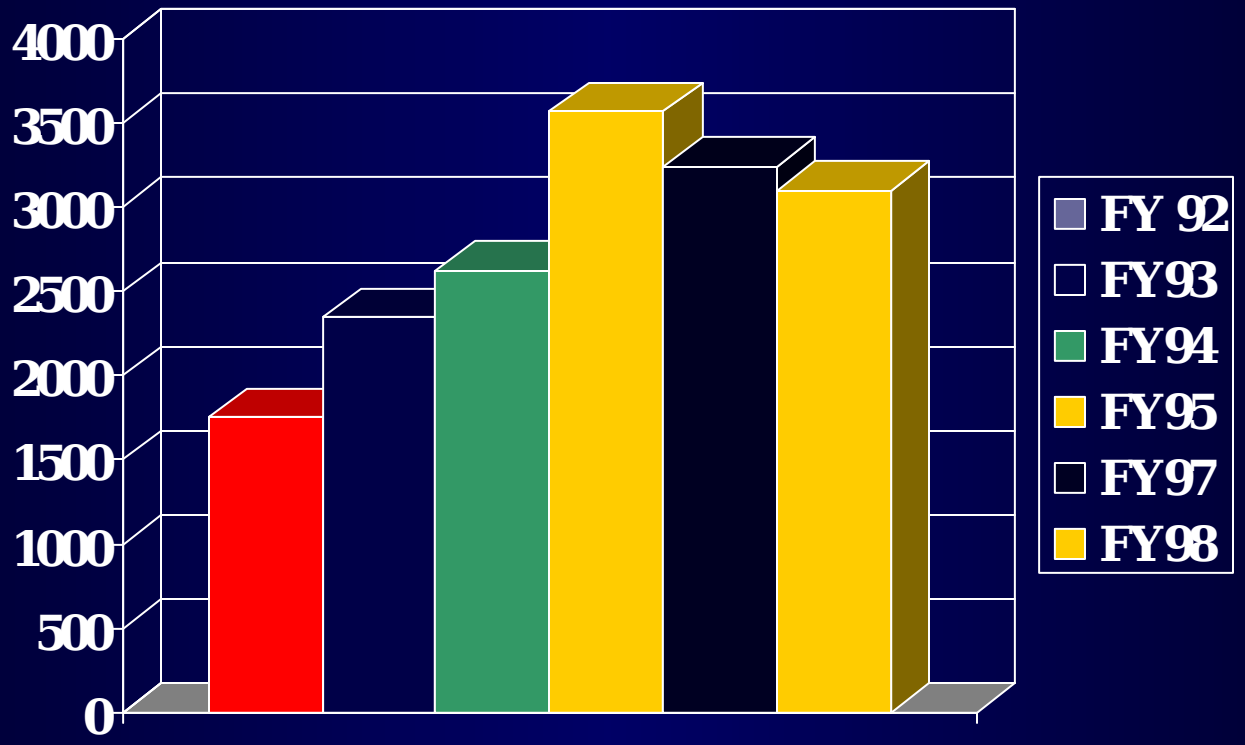
The Year in Review - 1998

- Start 7 day/24 hour access
  - Clinic open 361 days a year
  - PCM on call after hours
- Renovation Completed in April 1998
- Tricare Implemented April 1998
  - At >95% capacity on 2nd day of enrollment
- Lost control of Enrollment August 1998
  - Tasked with care for >4000 Prime enrollees for 7 months--could not put them in CHCS

The Year in Review - 1998

- Staffing:
  - Providers - 12
  - Nurses 6.5
  - Med Techs - 16
  - Admin Staff 5
- From 1996 to 1998 decreased Sick Call from 6 appts/provider to 3/provider

The Year in Review - 1998



Enrollment=15,698

85% appointments filled

The Year in Review - 1998

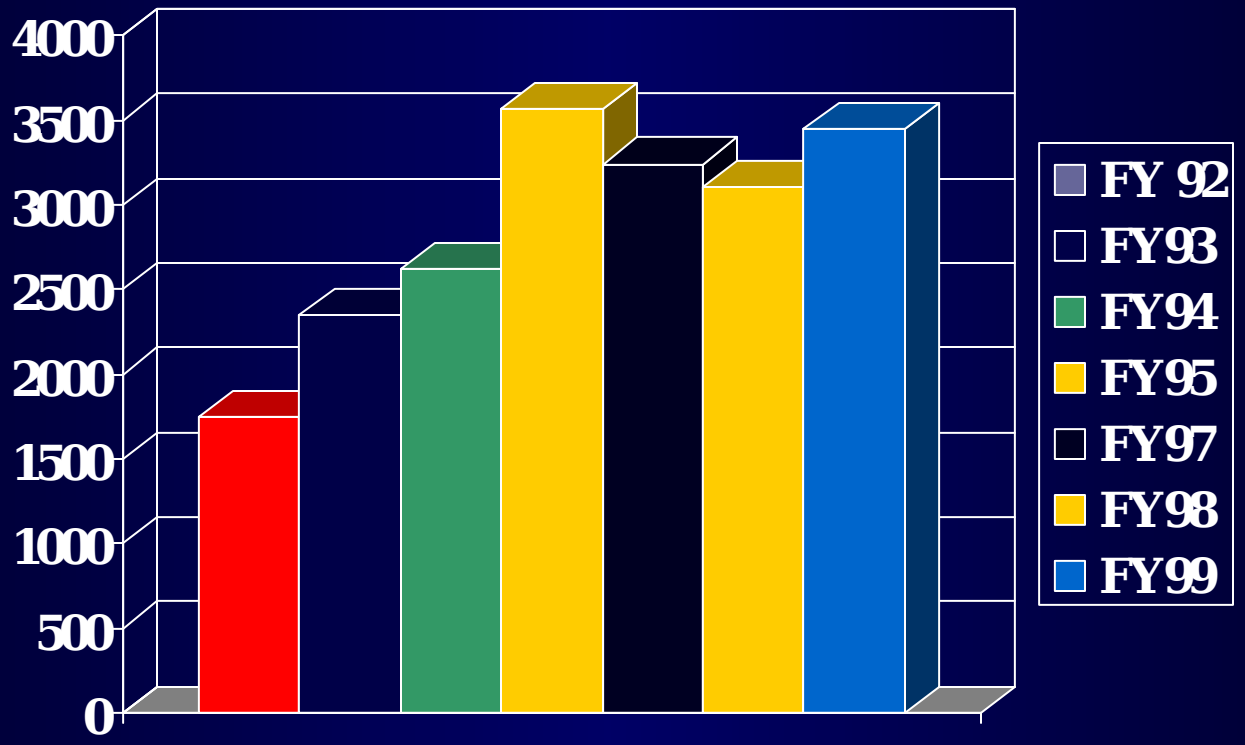
- Enrollment Mix
  - Active Duty 5217
  - Active Duty Dep 6220
  - Retiree 1495
  - Retiree Dep 2414
  - Other 3

The Year in Review - 1999

The Year in Review - 1999

- Scott Empanelment - 100%
  - 14,683 Total Enrollment 1,463/Provider
- Appointment Line 230 calls per day
- Average Hold Time 60 secs.
- No Shows Avg 160/month (4%)
- Open appts at the end of day->95%
  - Routines available 1-2 days
  - Acutes 12 hours

The Year in Review - 1999



Enrollment = 14,683

85% appointments filled

The Year in Review - 1999

- Enrollment! Enrollment! Enrollment!
  - Portability, Invalid enrollments, No Control
- Move to EBRM in the MTF
- Serious Investment in Population Health
- Staffing
  - Providers 10
  - Nurses 5
  - Med Techs 15
  - Admin Staff 4.5

The Year in Review - 1999

- Enrollment Mix
  - Active Duty 5294
  - Active Duty Dep 5763
  - Retiree 1238
  - Retiree Dep 2034
  - Medicare 352
  - Other 3

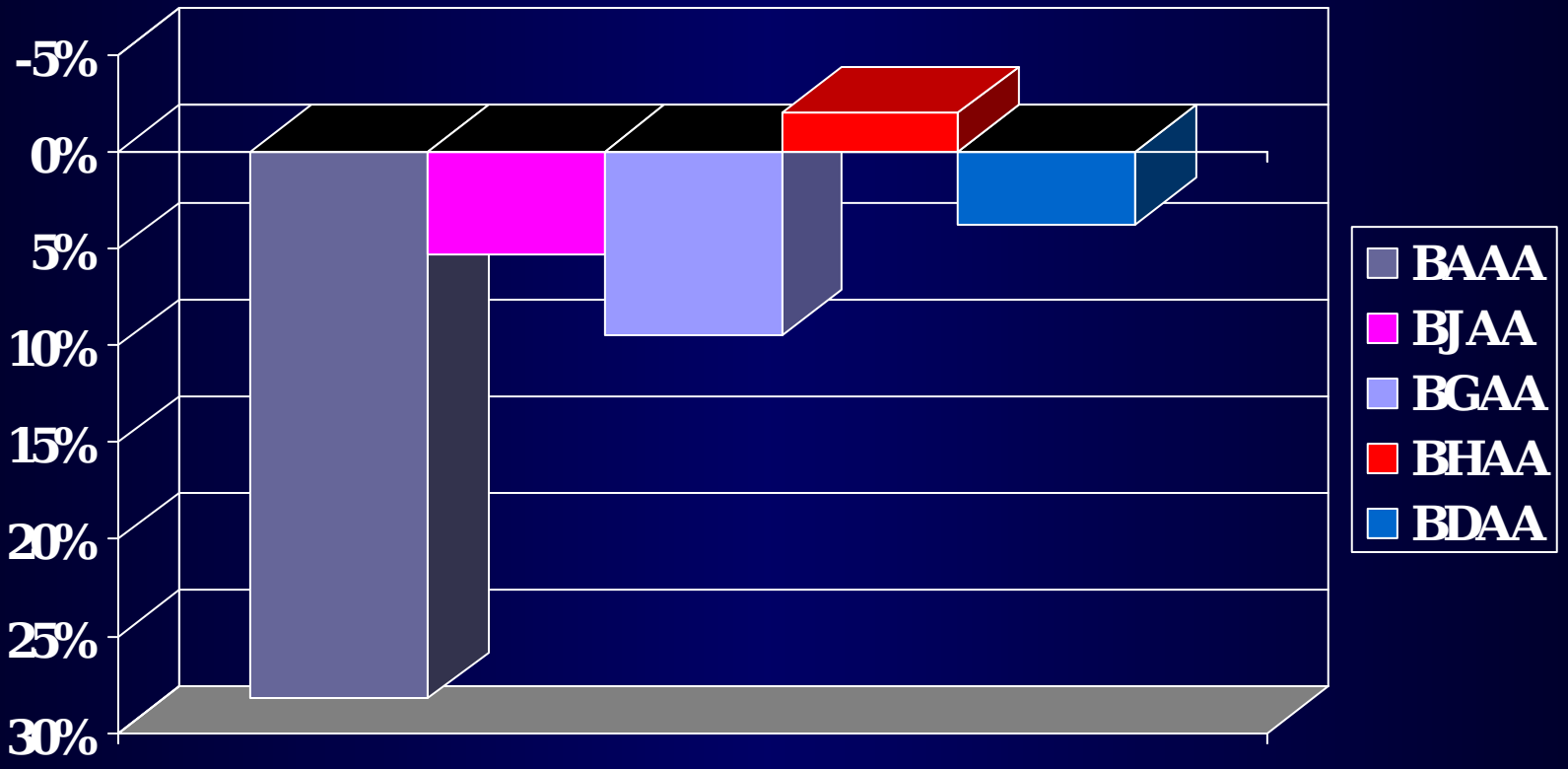
A Word About Data…….

Data Isn’t Information
Quality is The Key…..

- What data to Collect?
  - “Productivity”
  - Cost
  - Patient Outcome
  - Enrollment
- Depends on The Question….
  - Data Should Drive Management Decisions
- Quality = Information = Decision Tool

Change in number of appointments from 98 to 99 in Primary Care Clinics

1998 = 7915 **1999** = 7429 6% decrease



An Example at Scott…
MEPRS
CHCS Counts

- System Reliability - Excellent
- Office Hours and Lunch Hours - Variable
- Not entering patient encounters in CHCS
  - Walk-ins - Frequent problem
  - Keeping paper “Triple Nickels” in some clinics - A few clinics
- Not checking-in patients (creates un-kept appointments)
- Defining Appointment as “Count” vs “Non-Count”

The “Surprise”:

- *Summary*-- All of the issues are patient administration issues at the clinic level. The MEPR number is the best and most reliable number. The data can be used to confidently make decisions.
- *Impact*--on access, morale, integrity, data quality, and provider productivity

Productivity
Should We Look?

- Need to define- To us it is the measure of how well we fill capacity
  - Capacity Set By Templates- the goal is to fill ‘em up with “real” visits
  - Visit Numbers are a Function of:
    - Provider Availability
    - Support Staff- etc.
    - Demand Management Success
    - Template “Mix”- Unused Appointments Tell one a lot Here!

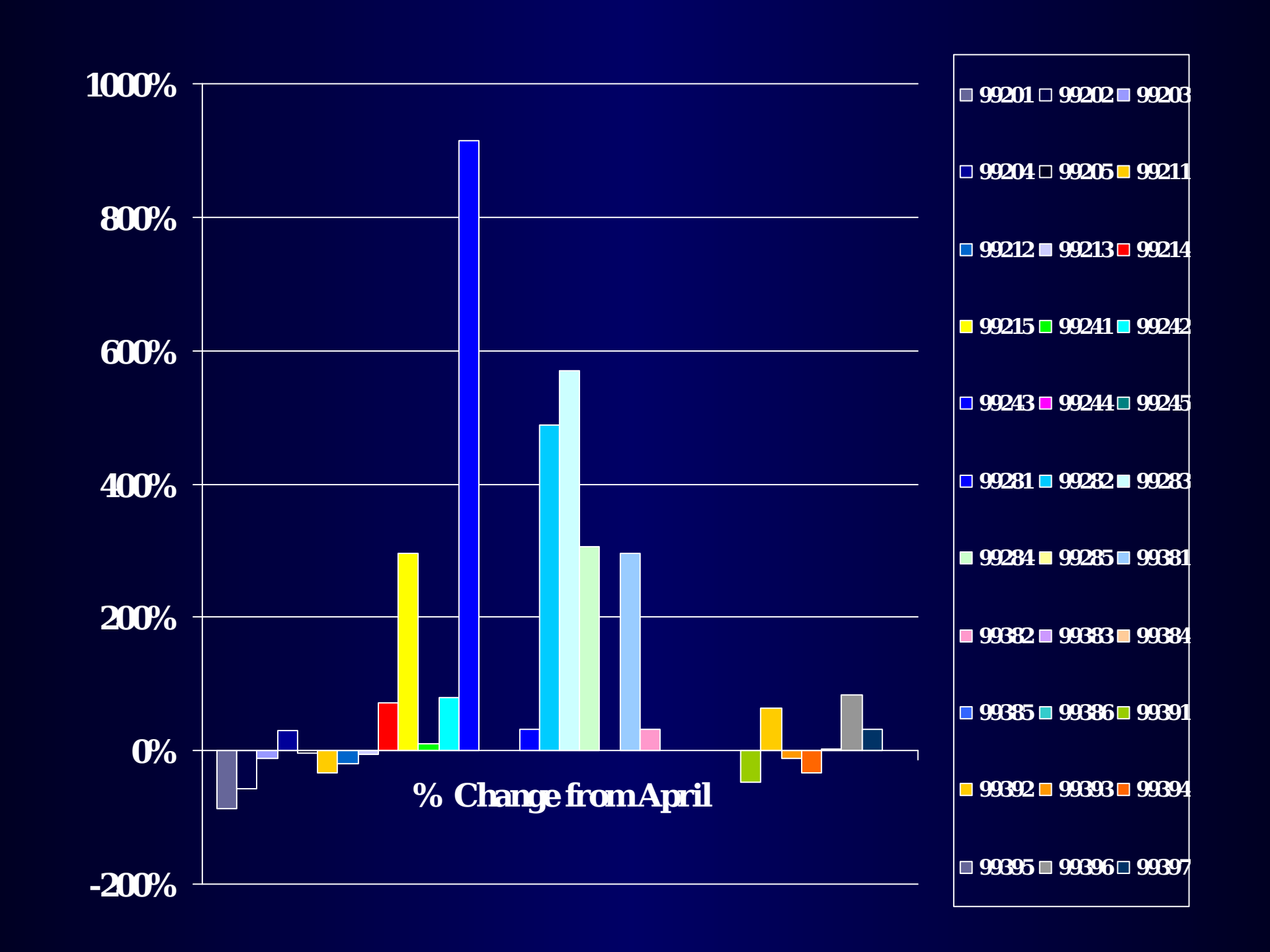
Since ADS is DoD Measurement Tool- What affects ADS counts At Scott?

- Not Getting Appointments From CHCS to CIW *
- Timeliness of Coding
  - After 14 calendar days then it is a not counted
- Unaware CIW encounters even exist
  - Immunizations, Pain Clinic, Dental Surgery, Family Advocacy, PES
- Duplicate Appointments
  - If a patient has two appointments in CHCS in a two hour then only one can be pushed over. Allergy, Neurology, etc.
- System Reliability

* CIW= Clinical Integrated Workstation- a Scott Unique Electronic Record System

What affects ADS counts?

- Unrecognized Codes
- “Why do I have to do this?”
  - It is not required as a part of the business practice of a provider-patient encounter
    - Over 7000 open notes on CIW--even after they were purged in April 1999.
  - Recommendation made months ago--CODE OR ELSE.
- Updating Key CHCS Tables
  - Provider Profiles, MEPR Codes, Etc.
  - Cost 20 providers weeks of coded visits in September, October, and November. 4 were Primary Care Providers--BIG impact!


1000%
800%
600%
400%
200%
0%
-200%
% Change from April
99201 99202 99203
99204 99205 99211
99212 99213 99214
99215 99241 99242
99243 99244 99245
99281 99282 99283
99284 99285 99381
99382 99383 99384
99385 99386 99391
99392 99393 99394
99395 99396 99397

No Matter What Data You Choose to Use, Analysis Is the Key to Converting it to Information One Can Use to Manage…..

Questions???

DEPARTMENT OF DEFENSE

TRICARE

Your Military Health Benefit

PRIME
EXTRA
STANDARD

TRICARE
www.tricare.osd.mil

World Class Health Care
for the World's Best Military